

**Corydon Animal Hospital  
1675 Corydon Ave.  
Winnipeg , MB R3N 0J8  
(204) 488-4577**

**Consent For Transfer of Medical Records**

Client Name:

Patient Name:

Address:

Species:

Telephone:

Age or Date of Birth:

I, the undersigned, do hereby authorize the Corydon Animal Hospital to disclose and transfer my personal information and my pet (s) medical records, including but not limited to x-rays and test results, quality assurance reports and any relevant information that may be deemed to be "personal information" under the Personal Information Protection and Electronic Documents Act ("PIPEDA").

I am aware there is a \$18.50 fee (plus tax) for this request that is to be paid by cash/debit or credit card and the file will be forwarded after payment is received.

Please send the above requested information to:

Clinic: \_\_\_\_\_ Fax number: \_\_\_\_\_

Fee: \$18.50 (plus tax)

Card Type: Visa \_\_\_ Mastercard \_\_\_ American Express \_\_\_ Debit \_\_\_

Credit Card Number: \_\_\_\_\_ Expiry date \_\_\_\_ / \_\_\_\_

Signature \_\_\_\_\_ Date: \_\_\_\_\_